TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AETNA LIFE INSURANCE COMPANY

Respondent Name
WC SOLUTIONS

MFDR Tracking Number
M4-11-4587-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 4, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Aetna Life Insurance asserts that it paid medical service claims totaling $203.60 which clearly should have been billed to, and paid in good faith by the workers' compensation carrier in this case. The carrier has never disputed the compensability of the injury. The carrier has never offered a substantive objection to the compensability of the services."

Amount in Dispute: $203.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached it an EOB recommending payment of $195.55, which is the Medical Fee Guideline for Texas Workers' Compensation claims. This is being forwarded to Edwards Claims Administration, the TPA, for payment."

Response Submitted by: Starr Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 1, 2010	99213, 73110, Q4010 and 29085	$203.60	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - P12 – Workers' compensation jurisdictional fee schedule adjustment
    - W3/P12 – Additional payment made upon reconsideration

Issues

1. Did the insurance carrier issue payment for the disputed services rendered on May 1, 2010?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code §134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The requestor seeks a total reimbursement in the amount of $203.60. Review of the submitted documentation in the form of EOBs submitted by the insurance carrier supports that payment in the amount of $195.55 was issued to the requestor for disputed date of service May 1, 2010. As a result, the requestor is not entitled to additional reimbursement for the disputed CPT codes.
2. Review of the submitted documentation finds that the requestor is not entitled to additional reimbursement for the disputed CPT codes 99213, 73110, Q4010 and 29085 rendered on May 1, 2010. The insurance carrier submitted sufficient documentation to support that a payment was issued according to the Medical Fee Guidelines in affect at the time the disputed services were rendered.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 16, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.